

WACH Warfighter Refractive Eye Surgery Program WTU Application Form

The Warfighter Refractive Eye Surgery Program (WRESP) is open to all eligible active duty Army personnel who meet the criteria determined by the Army Chief of Staff and the Surgeon General.

The following soldier (Name).....

(Rank).....

(Last Four).....

Is in the Warrior Transition Unit (WTU) at..... and has applied to be considered for refractive surgery under the WRESP. The soldier must be medically and physically ready for surgery, must show intent to return to active duty status once they are released from the WTU and have at least 18 months remaining on their enlistment at the time they expect to have this surgery.

I am the Case Manager for and certify he / she has stated his / her intention to return to active duty following their release from the Warrior Transition Unit (WTU).

.....
Printed Name

.....
Signature

.....
Date

.....
Contact Phone

I am the Medical Officer Designator for and certify that he / she is a medically and physically appropriate candidate for refractive surgery.

.....
Printed Name

.....
Signature

.....
Date

.....
Contact Phone

WACH Warfighter Refractive Eye Surgery Program

Application Information and Instructions

Application Documents

Your application package for refractive surgery in the Warfighter Refractive Eye Surgery Program must include the following documents (see below for additional details):

- **Enrollment and Post-Operative Care Agreement**
 - **Must be 21 years old**
- **Commander's Authorization**
- **Referral Form**
- **Medical History Sheet**
 - **Contact Lenses must be out for 2 weeks prior to your PREOP Evaluation!**

If you want to have your post-surgery follow-up care managed by an Army Medical Facility other than Winn Army Community Hospital, you must complete the:

- **Managed Care Agreement**

If you are in the Warrior Transition Unit you must complete the:

- **WTU Application Form**

Document Instructions

Please complete ALL the information in the forms and ensure it is LEGIBLE. So please print. Applications with missing or have illegible information could experience delays in booking.

- **Enrollment and Post-Operative Care Agreement** - You must complete and initial one of the Eligibility Statements in the Enrollment Form. If neither applies, you are not eligible for treatment.
- **Commander's Authorization** - Will be signed by your Brigade or Battalion Commander (O5 or above). No exceptions. This authorization covers the required six month period for follow-up appointments. Surgical appointments should be made within the first 90 days from the date of this authorization.
- **Referral Form** - For all applicants NOT stationed at **FORT STEWART**. This form must be completed by your local optometry provider where indicated. You need to have a current manifest refraction unless you have had one within the past year, in which case your provider can simply transcribe the prior exam results.
- **Managed Care Agreement** - For all applicants NOT stationed at Fort Stewart. This agreement must be completed in advance and submitted with original packet. This form must be completed by you and signed by the optometry provider who agrees to manage your post-operative care.
- **WTU Application Form** - Must be completed by all candidates that are assigned to WTU.

Submission of Application

Hand submits your application packet in its entirety to the WRESP Coordinator. Your packet will be reviewed on the spot and a pre-operative examination (PREOP) appointment will be made for you at that time. You are required to **bring your glasses** with you for that appointment and to be out of your contact lenses for at least **2 weeks**. If you have questions regarding any part of this packet, contact the WRESP Coordinator at (912) 767-2020.

Please note that this program is a mission readiness initiative and entry is based on priority. First priority is given to soldiers deploying to SW Asia in support of the Global War on Terrorism. All other active duty personnel who meet the basic program requirements are eligible for treatment on a space available basis and are encouraged to submit applications as they may be offered entry into a non-priority based surgery program.

PLEASE READ THIS PACKET VERY CAREFULLY. THE APPLICANT IS RESPONSIBLE FOR ALL PARTS OF THIS PACKET. COMPLETED PACKETS WILL ONLY BE ACCEPTED.

WACH Warfighter Refractive Eye Surgery Program Enrollment and Post-Operative Care Agreement

(TO BE SUBMITTED BY ALL APPLICANTS)

Enrollment Information (Complete all blanks)

Patient Name (Print) (Last / First / MI)			Rank	SSN	
MOS	Assigned Unit	Military Installation	Age	Date of Birth	ETS Date
USA USAR NG Other (Circle One)	Deploying? (Yes/ No)	If Yes when? (ddmmmyyyy) (Date example. 01 APR 2009)	PCS'ing (Yes/ No)	If Yes when? (ddmmmyyyy)	
Contact address					
Contact Phone (Day)		Contact Phone (Evenings)	Cell Phone		
Email Address (AKO Preferred)					

Eligibility Statement (Initial the statement that applies to you)

_____ I am Active Duty US Army and will not deactivate, ETS or discharge within 18 months of my surgery..

_____ I am a member of the National Guard or Reserves in AGR status or activated status with _____ months remaining on active duty and will not deactivate, ETS or discharge within 18 months of my surgery.

Post-Operative Care Agreement (Initial each statement)

_____ I will contact Winn Army Community Hospital WRESP or my local Optometry Clinic to schedule my 30-day follow-up appointment as soon as I am notified of my surgery date.

Note that if you are NOT returning to Winn Army Community Hospital for your post-operative care a Managed Care Agreement must be completed as part of your application package.

_____ I understand that post-operative follow-up appointments are required at 1, 3, 6 and 12 months. If I am deploying before the 6-month exam is due I will complete the 1- and 3-month exams and then return to WACH, or to the facility designated in my Managed Care Agreement for a post-operative exam at the completion of my deployment.

_____ If PRK is recommended by the refractive surgeon, I am considered non-deployable for three months; if LASIK is recommended, I am considered non-deployable for one month.

Patient Signature	Date
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WACH Warfighter Refractive Eye Surgery Program Commander's Authorization

(TO BE SUBMITTED BY ALL APPLICANTS)

(1) I give my permission for the following active duty soldier to be considered for enrollment in the Warfighter Refractive Eye Surgery Program (WRESP) and for treatment if eligible.

Patient Name (Print) (Last / First / MI)

Rank SSN

Email Address (AKO Preferred)

(2) I certify the following to be true:

- The soldier has at least **18 MONTHS** remaining on **ACTIVE DUTY**.
- The soldier has no adverse personnel actions pending including medical boards.
- The soldier will remain **CONUS** and is **NON-DEPLOYABLE** with the following considerations:
If LASIK, non-deployable for 1 month
If PRK, non-deployable for 3 months.
- If deployment is scheduled, I request that laser surgery be completed by _____.
DATE

(3) I realize that after laser eye surgery, the soldier will be **RECOMMENDED CONVALESCENT LEAVE** up to **96 HOURS** and will have the following **PHYSICAL PROFILE** for a minimum of **30 DAYS**, but possibly up to 90 days in a small number of patients (<10%):

- Recommend no dusty environments.
- Recommend no underwater activities.
- Recommend no driving military vehicles for 2 weeks.
- **Need to wear sunglasses at all times for 90 days following surgery (profile will be given).**

(4) I acknowledge that **NATIONAL GUARD** and **RESERVE** soldiers are **NOT** eligible for treatment unless they have been activated and have at least **18 MONTHS ACTIVE DUTY** remaining at the time of their surgery.

(5) I acknowledge this soldier is required to complete 1, 3, 6 and 12-month **FOLLOW-UP EXAMS** required by the Warfighter Refractive Eye Surgery Program. Or if deploying before the 6-month exam is due they are required to complete the 1- and 3-month exams and then return to WACH or co-managing optometry clinic for a post-operative exam at the completion of their deployment.

(6) Failure to comply with the post-operative care requirements may affect future enrollments from the soldier's unit.

(7) This authorization is good for 90 days from the date that it is signed.

Commander's Signature

Commander's Rank and Name (Print) (O5 or above)

Date

Commander's Email Address

Commander's Telephone Number

Applicant's Signature

Date

**THIS FORM MUST BE COMPLETED AND DELIVERED TO THE WRESP-FSG
KEEP A COPY FOR YOUR RECORDS
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Clinical Reviewer's Signature: _____

Name (Last, First, M.I.) _____ Rank _____ Unit: _____ SSN (Last four) _____ Date: ____ / ____ / ____

YOUR EYE HISTORY

How long have you used eyeglasses? Number of years: _____, Since age: _____ Do you have trouble with bright lights or night vision? Y N

Do you wear contact lenses? Y N If so, what type of contact lenses? __Soft __Toric __Hard __Rigid Gas Permeable __Disposable __Sleep in lenses?

When did you last have lenses in your eyes? _____ Have you ever had a corneal abrasion or erosion? Y N Viral eye infection? Y N

Have you ever developed intolerance to contact lenses? Y N Have you ever been treated for, or been told you have any of the following?:

___ Amblyopia/Lazy Eye ___ Glaucoma ___ Elevated eye pressure ___ Cataract ___ Strabismus/Eye turned ___ Retinal disease

___ Corneal disease ___ Keratoconus ___ Double vision ___ Dry eyes ___ Herpes in or near eye ___ Prism in eyeglasses

Have you ever had any surgery, injuries, or laser treatments to your eyes? Y N Please list: _____

Please list any eye drops or ointments you are using:(including over-the-counter): _____

MEDICAL HISTORY

Do you have or have you ever been treated for the following?:

___ Connective tissue, autoimmune disease, or immuno-deficiency (e.g. Rheumatoid Arthritis, Lupus, Sarcoid, thyroid disease, organ-transplant, or H.I V.?)

___ Taken any of these medications?: Accutane (isoretinoin) for acne treatment, or Cordarone (amiodarone hydrochloride) for controlling irregular heartbeat, or Imitrex for migraine headaches?

___ Formed keloids? (e.g. heavy scarring over cuts, stitches, or surgical incisions?)

(For women) Have you been pregnant or nursing within the last 3 months: Y N

In Your Family: (parents and/or siblings only): Is there a family history of:

___ Cataracts ___ Glaucoma ___ Strabismus (Lazy Eye) ___ Retinal Disease ___ Diabetes ___ Keratoconus (or other corneal diseases)

___ Blindness: If so, please explain: _____

You: Do you have, or have you ever been treated for the following:

___ Stroke ___ Asthma ___ Ulcer ___ Hepatitis B or C ___ Liver Disease

___ Seizure ___ Chronic Cough ___ Stomach or Intestinal Disease ___ Arthritis ___ Kidney Disease

___ Brain Tumor ___ Multiple Sclerosis ___ High Blood Pressure ___ Heart Disease ___ Eczema or Atopic Dermatitis

___ Cancer or tumors? Please explain: _____

___ Diabetes? If so, for how long? _____ Using insulin? Y N

Please list all medications you are **ALLERGIC** to: _____Please list all medications and dosages you are **CURRENTLY** taking, including non-prescribed and over-the-counter medicines: _____

Please list any surgeries you have had: _____

Patient Statement: "I certify that the above information is complete and correct to the best of my knowledge." (Signed) _____

**WACH Warfighter Refractive Eye Surgery Program
Referral Form**
(TO BE SUBMITTED BY ALL APPLICANTS NOT AT FORT STEWART)

Patient Name (Print) _____ Rank _____ SSN _____

Email Address (AKO Preferred) _____

Contact Lens History _____

CONTACT LENS WEARERS Please read and initial the appropriate requirement:

_____ I wear **SOFT CONTACT LENSES** and will be out of them for at least **TWO WEEKS** before all appointments.

_____ I **SLEEP** in my **SOFT** lenses or wear **GAS PERMEABLE** or **TORIC** soft contact lenses and will be out of them for at least **THREE WEEKS** before any appointment.

EXAMINING PROVIDER

EXCLUDE patients who answer **YES** to any of the following:

- Refraction has **CHANGED** more than **0.50 DIOPTERS** in one year? YES / NO
- Has taken **IMITREX & ACCUTANE** or **STEROIDS** within the past **YEAR**? YES / NO
- Has a history of **KERATOCONUS**? YES / NO
- Is **PREGNANT, PLANNING** to become pregnant or **NURSING**? YES / NO
- Has had a **SMALLPOX** vaccination within the **PAST THREE MONTHS**? YES (Date) / NO

Note that ALL of the following **MUST** be completed for a valid application. If the applicant has had a manifest refraction within the past year the data can be recorded without the need for a repeat refraction.

OD	OS
CURRENT GLASSES RX _____ x _____ 20 / _____ _____ x _____ 20 / _____	
DATE OF GLASSES RX _____	
MANIFEST RX _____ x _____ 20 / _____ _____ x _____ 20 / _____	

Date: _____ Examining Provider: _____

WACH Warfighter Refractive Eye Surgery Program
Managed Care Agreement
(FOR POST-OPERATIVE CARE AT A FACILITY OTHER THAN FORT STEWART)

Patient Name (Print) Rank SSN

Military Installation Phone E-mail

In the next 6 months are you: _____
Deploying (Yes/No) If Yes when? (ddmmmyyyy) PSC (Yes/ No) If Yes when? (ddmmmyyyy)
(Date example. 01 APR 2009)

Patient Agreement (initial each statement)

_____ I request to be returned to my Optometry Clinic at _____
for post-operative care following refractive surgery at Fort Stewart, Georgia. The Refractive Surgery Center staff will
be available for additional consultation as needed.

_____ I will contact this Optometry Clinic to schedule my first follow-up appointment as soon as I am notified of my
surgery date.

_____ I understand that post-operative follow-up appointments are required at 1-week, 1-, 3-, 6- and 12-months.
If I am deploying before the 6-month exam is due I will complete the 1-week, 1- and 3-month exams and then return
to this Optometry Clinic for a post-operative exam at the completion of my deployment.

Patient Signature Date

Co-Managing Provider's Agreement (Initial each statement)

_____ I agree that I will manage this patient and accept responsibility for his/her post-operative care. Post-operative
appointments will be scheduled at 1-week, 1-,3-,6- and 12-months. If the soldier is deploying before the 6-month
exam is due then they will complete the 1- and 3-month exams and then return for a post-operative exam at the
completion of their deployment.

_____ I will email or fax the results of each follow-up exam to the Warfighter Refractive Eye Services at Fort
Stewart, Georgia.

Optometrist Stamp/Signature Optometrist's Name (Print) Rank Date

Military Installation Phone Fax Email